Supreme Court, U.S.
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No. _____

IN THE
SUPREME COURT OF THE UNITED STATES

NATALIE KERWICK,

*Petitioner,*

v.

COMMISSIONER OF SOCIAL SECURITY,

*Respondent.*

**On Petition For Writ of Certiorari To The United States Court Of Appeals For The Eleventh Circuit**

# PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

1. Whether the Commissioner of Social Security, in determining if the claimant is disabled within the meaning of Title II of the Social Security Act, must weigh the opinion of the treating physician using all of the factors provided in 20 C.F.R. § 404.1527 and 416.927?

2. Whether the Commissioner of Social Security, in determining if the claimant is disabled within the meaning of Title II of the Social Security Act, must give weight to the opinion of the treating specialist in claims in which the claimant's impairments stem from a rare disease?

## PARTIES TO THE PROCEEDING

There are no parties to the proceedings other than those listed in the caption.

Pursuant to Rule 29.6, Petitioner states that no parties are corporations.

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## PETITION FOR A WRIT OF CERTIORARI

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Petitioner Natalie Kerwick respectfully requests that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Eleventh Circuit in this case.

## OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-4) is unreported. The opinion of the district court (Pet. App. 6-24) is unreported.

## JURISDICTION

The judgment of the court of appeals was entered on January 18, 2006. On April 12, 2006, Justice Thomas extended the time within which to file a petition for a writ of certiorari to and including June 16, 2006. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## STATUTORY PROVISIONS INVOLVED STATEMENT

Relevant provisions of the Social Security Act, 42 U.S.C. 423(d) et seq. and implementing regulations, 20 C.F.R. Pts. 404 and 416 are set forth in the Appendix to the petition, Pet. App. 25-48.

## STATEMENT

Title II of the Social Security Act mandates eligibility of Social Security benefits to disabled workers. This case concerns the weight of the evidence needed to establish "disability" for the purposes of being awarded benefits under the Social Security Act. Specifically, it presents the questions whether the Commissioner of Social Security, in determining if the claimant is disabled within the meaning of Title II of the Social Security Act, must weigh the opinion of the treating physician using all of the factors provided in 20 C.F.R. 404.1527 and whether the opinion of the treating specialist is entitled to greater deference in claims in which claimant's impairments stem from a rare disease.

### A. Statutory and Regulatory Framework

Title II of the Social Security Act defines "disability" as the inability to engage in "any substantial gainful activity by reason of an impairment which can be expected to result in death" or last the specified duration. 42 U.S.C. 423(d)(1)(A). "The impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 20 C.F.R. 404.1508.

In evaluating a disability claim, the Commissioner has implemented a five-step sequential evaluation process. 20 C.F.R. 404.1520. The five steps are as follows: Step one, if the claimant is engaged in substantial gainful activity; Step two, the

medical severity of the claimant's impairments; Step three, if the claimant's impairments meet or equals the Listings and duration requirement, Step four, the claimant residual functional capacity and his or her ability to perform relevant past work; Step five residual functional capacity, the claimant age, education, work experience in evaluating if they can adjust to other work. *Id.*

If the claimant is found disabled or not disabled at a step, then the determination or decision is made and further steps are not considered. *Id.* If disabled or not disabled is undeterminable at a step then the following step is considered. *Id.* Before progressing from step three to step four, the residual functional capacity of the claimant is assessed. *Id.* The residual functional capacity is used in evaluating step four and step five. *Id.*

The residual functional capacity assessment evaluates the claimant's impairments and any related symptoms, such as pain, that may cause physical or mental limitations that affect the claimant's performance in a work setting. *See* 20 CFR 404.1545. The residual functional capacity is based on all the relevant evidence in the record. *Id.* Relevant evidence includes medical and other evidence. *Id.* Such as, statements made about what the claimant can do provided by medical sources, whether or not they are based on formal medical examinations. *See* CFR 404.1513. Other evidence that will be consider are descriptions and observations of the claimant's limitations from his or her impairments, including limitations that result from claimant's symptoms, such as pain, provided by claimant, claimant's family or friends. *See* 20 CFR 404.1545.

All medical evidence and opinions, regardless of its source, are evaluated in determining disability. *See* 20 CFR 404.1527(d). Unless the "treating source's opinion" is given controlling weight, "the following factors are considered in deciding the weight given to any medical opinion." 20 CFR 404.1527(d)(1). The factors are: (1) Examining relationship, (2) Treatment relationship, (3) Supportability meaning the more a medical source presents relevant evidence to support an

opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion, (4) Consistency meaning the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion, (5) Specialization meaning that in general give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist, and (6) Other factors. *See* 20 CFR 404.1527(d)(1-6).

If it is found that a "treating source's opinion on the issue(s) of the nature and severity of [the claimant's] impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record", controlling weight will be given. *See* 20 CFR 404.1527(d)(2). If the treating source's opinion is not given controlling weight, the remaining factors are applied in "determining the weight to give the opinion." Good reasons must be given in the "notice of determination or decision for the weight" given the "treating source's opinion." *Id.*

In general, the "longer a treating source has treated [the claimant] and the more times [the claimant] has been seen by a treating source", the greater the weight given to the "source's medical opinion." *See* 20 CFR 404.1527(d)(2)(I). In general the "more knowledge a treating source has about the impairment" the greater the weight given the opinion of the treating source. The treatment the source has provided will be considered, as well as, "the kinds and extent of examinations testing the source has performed or ordered from specialists and independent laboratories." See 20 CFR 404.1527(d)(2).

The Commissioner has issued formal Social Security Rulings interpreting the application of the five factors in evaluating the weight given to a treating sources opinion. If the opinions of the treating physician are inconsistent with other substantial evidence, the treating doctor's opinion is not entitled to controlling weight, but completely rejecting the opinion is

not an accurate interpretation of 20 C.F.R. § 404.1527 (d)(2). Social Security Ruling (SSR) 96-2p (1996) (*available in* 1996 WL 374188, 1, 4). "Treating source medical opinions are still entitled to deference and must be weighed using all of the factors provided in 20 C.F.R. § 404.1527 and 416.927." *See Id.* at 4. "In many cases, a treating source's medical opinion will be entitled to the greatest weight and should be adopted, even if it does not meet the test for controlling weight." *See Id.* Thus, the importance of a treating source's opinion is not easily rejected and each factor in 20 C.F.R. § 404.1527 (d)(2) must be considered and discussed.

**B. The Proceeding In This Case**

Petitioner Natalie Kerwick, was twenty-one years old at the time of her administrative hearing. Petitioner alleges that she became disabled on February 8, 1981 due to a capillary-venous-lymphatic malformation of the right lower extremity, which resulted in amputation of her right leg below the knee and subsequent surgeries for infections and contouring of the stump.

Petitioner filed an application for Childhood Disability Benefits on October 6, 1998. (Pet. App. 9). The application was initially denied. (Id.). Petitioner filed a Request for Reconsideration on May 5, 1999. (Id.). The Social Security Administration affirmed its decision. (Id.). Petitioner filed a request for a hearing by an Administrative Law Judge (ALJ). (Id.). A hearing was held on June 7, 2000 and ALJ Rivera issued an unfavorable decision on August 14, 2000. (Id.). A request for review was timely filed. (Id.).

In an order dated February 2, 2002, the Appeals Council issued a Remand Order vacating ALJ Rivera's decision and remanded the case for further proceedings. (Id.). A hearing was held on April 12, 2002 and a supplemental hearing was held on June 6, 2002. (Id.). On August 12, 2002, ALJ Rivera issued an unfavorable decision. (Id.) The ALJ found that petitioner was not disabled, and had the residual functional capacity to perform the exertional demands of light work

reduced by non-exertional limitations, secondary to right leg amputation, that result in the need to alternate sitting and standing during the course of an 8-hour workday. (Pet. App. 14-15). The ALJ dismissed the opinion of Dr. Mulliken[1], the treating physician and specialist, by finding that it was inconsistent with the weight of the record when considered in its entirety and therefore should be given little weight.(Pet. App. 19). The ALJ noted that the opinion of Ira Woletsky, M.D.[2], a pediatrician, was given considerable weight as it was supported by medical findings in the record. In addition, the ALJ gave some probative weight to K. Seo M.D.[3] (Pet. App. 21). The

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[1]Dr. Mulliken is a specialist in vascular birthmarks/ hemangiomas and malformations (Pet. App. 11). He has examined, treated, and operated on Petitioner from August 4, 1984 to June 1, 2000 (Pet. App. 11, 20). Dr. Mulliken has performed multiple procedures on petitioner, including: knee disarticulation with contouring stump; debulking of the right buttock and above the right knee amputation; shortening, right below-knee amputation of the stump; contour excision of the right buttock and upper thigh; excision of the infected wound in her right thigh; contour resection, overgrown tissue, right upper buttock, resection, pedunculated lymphatico-venous masss, right perineum (Pet. App. 11-12).

In 2000, Dr. Mulliken completed a Physical Capacities Evaluation (PCE) and Pain Interrogatory (PI) regarding petitioner's work limitations. (Pet. App. 20). The doctor reported that petitioner could stand/walk for a maximum of 2 hours and sit for a maximum of 3 hours in an 8 hour work day. (Id.). In addition, the doctor reported that petitioner can occasionally lift 11 - 20 pounds. (Id.) Dr. Mulliken also reported that Ms. Kerwick could not use her feet for repetitive movements, as in operating foot controls, crawling, or climbing. (Id.).

[2]Petitioner has been examined and treated by Ira Woletsky, M.D., a pediatrician, since November 18, 1983. (Pet. App. 4, 21). For disability determination, Dr. Woletsky completed an assessment of petitioner in 1999. (Id.). Dr. Woletsky reported that petitioner's ability to lift and carry is limited and that she can lift and/or carry a maximum of 25 pounds. (Id.). Dr. Woletsky also indicated that petitioner's ability to stand and/or walk is limited and that she can stand and/or walk up to 2 hours per day. (Id.).

[3]On March 22, 1999, Petitioner was examined by K. Seo, M.D., North Broadway Medical Associates, for disability determination. (Pet. App. 13). Dr. Seo reported that petitioner walked into the examining room limping due

ALJ found that the opinion of Dr. Anthony Buonocore, a state agency medical consultant, was given considerable weight and supported by the medical record as a whole (Pet. Appl. 21-22).

The Appeals Council denied petitioner's request for review.

The district court affirmed. After reviewing petitioner's claimed impairments in detail, the district court concluded that the ALJ properly stated the requisite good cause and substantial evidence supports his finding in regards to the amount of weight given the treating physician. (Pet. App. 19-24). In addition, the district court determined that the substantial amount of weight given to Dr. Wotezky opinion by the ALJ was validly based upon substantial evidence in the record, as well as the weight given to the opinions of Dr. Buonocore and Dr. Seo. (Pet. App. 21-22).

The court of appeals affirmed. The court concluded that the opinion of Dr. Mulliken, a treating physician and a specialist was inconsistent with the weight of the record in its entirety. (Pet. App. 3-4). The court found that the ALJ demonstrated good cause for this conclusion by relying on petitioner's high school attendance, other medical opinions in the record, and petitioner's own testimony. (Id.).

Petitioner petitioned for a rehearing which was denied by the court of appeals. (Pet. App. 5).

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to a heavy prosthesis on her right leg and had difficulty standing up from the sitting position. (Id.). In addition, Dr. Seo reported that petitioner had difficulty getting on and off the examining table with the prosthesis; without the prosthesis, obvious difficulty. (Id.). Dr. Seo's impression was that petitioner was able to sit without much difficulty, able to stand less than one hour in an 8 hour working period, able to walk a couple of blocks, and able to lift and carry less than 10 pounds. (Pet. App. 21). Dr. Seo noted, "Considering hemangioma in nature, prognosis is poor. Presently, she is using a long leg prosthesis, however, it may be difficult using the long leg prosthesis considering hemangioma, weight bearing is also difficult. I believe considering extensive hemangiomatas lesions of the right thigh, probably requires another debulking procedure. Probably she is disabled." (Tr. 214).

## REASONS FOR GRANTING THE PETITION

The court of appeals in this case permitted the Commissioner to disregard its own interpretation of 20 C.F.R. § 404.1527, holding that the treating source's opinion was inconsistent with the evidence in the entirety, therefore entitling the ALJ to reject it. The court's decision is in direct conflict with the decisions of three other circuits. *See Newton v. Apfel*, 209 F.3d 448, 456 (5th Cir. 2000) refering *Clark v. Commissioner of Social Security*, 143 F.3d 115, 118 (2d Cir. 1998); *Goatcher v. U.S. Department of Health & Human Servs.*, 52 F. 3d 288, 290 (10th Cir. 1995); *Schaal v. Apfel*, 134 F.3d 496, 504 (2d Cir. 1998); dissent in *Prosch v. Apfel*, 201 F.3d 1010, 1116 (8th Cir. 1999).

By finding that the treating specialist's opinion was inconsistent with the evidence in the entirety, thus, the ALJ was entitled to reject it, the court appeals did not consider the necessity of a specialist's opinion in claims involving rare diseases.

### A. The Eleventh Circuit's Decision Conflicts With Decisions of Three Other Courts Of Appeals.

The Commissioner must evaluate the medical evidence to determine if the claimant's impairments render her physically or mentally incapable of performing substantial gainful activity. The Commissioner "makes a finding about the residual functional capacity based on all the relevant medical and other evidence in the case record." 20 C.F.R. §404.1520.

In evaluating the weight of the medical evidence, it is well established that a treating source's opinion is entitled to controlling weight in certain circumstances. "If the commissioner finds that a treating source's opinion on the issue of the nature and severity of the plaintiff's impairments is well supported by the medically acceptable clinical and lab diagnostic techniques and is not inconsistent with other substantial evidence, the commissioner will give it controlling

weight." *See* 20 C.F.R. § 404.1527 (d)(2). If the opinions of the treating physician are inconsistent with other substantial evidence, the treating doctor's opinion is not entitled to controlling weight, but completely rejecting the opinion is not an accurate interpretation of 20 C.F.R. § 404.1527 (d)(2). *See* SSR 96-2p (1996) (*available in* 1996 WL 374188, at 1, 4). "Treating source medical opinions are still entitled to deference and must be weighed using all of the factors provided in 20 C.F.R. § 404.1527 and 416.927." *See Id.* at 4. "In many cases, a treating source's medical opinion will be entitled to the greatest weight and should be adopted, even if it does not meet the test for controlling weight." *See Id.*

If an opinion of a treating source is not given controlling weight, the regulations direct an ALJ to consider a series of factors to determine the weight to give the opinion. 20 C.F.R. § 404.1527 (d). The factors an ALJ ***must*** consider are: (1) the length of the treatment relationship; (2) the nature and extent of the treatment relationship; (3) the quantity of evidence in support of the opinion; (4) the consistency of the opinion with the record as a whole; and (5) whether the treating physician is also a specialist (emphasis added). *Id.* Several federal courts have found that an ALJ must consider each of the § 404.1527 (d) factors in determining whether to reject or give little weight to the opinion of a treating specialist physician. *See Newton v. Apfel*, 209 F.3d 448, 456 (5th Cir. 2000); *Clark v. Commissioner of Social Security*, 143 F.3d 115, 118 (2d Cir. 1998); *Goatcher v. U.S. Department of Health & Human Servs.*, 52 F. 3d 288, 290 (10th Cir. 1995); *Schaal v. Apfel*, 134 F.3d 496, 504 (2d Cir. 1998); dissent in *Prosch v. Apfel*, 201 F.3d 1010, 1116 (8th Cir. 1999).

In *Schaal,* the Second Circuit interpreted the 1991 Regulations [56 Fed.Reg. 36,932(1991)]regarding the weight of a treating doctor's opinion, finding that an ALJ's failure to consider ***all the factors*** listed in 20 C.F.R. § 404.1527 (d)(2)(i) was a legal error (emphasis added). *Schaal v. Apfel*, 134 F.3d 496, 504 (2d Cir. 1998).

In *Clark v. Commissioner of Social Security*, the Second Circuit relied on *Schaal* in remanding the case to the District Court. In determining if the SSA's decision was based on substantial evidence and proper legal standard, the Second Circuit examined the weight given to the opinions of treating sources. *Clark*, 143 F.3d 115, 118 (2d Cir. 1998). The Second Circuit found that when controlling weight is not given to the treating sources' opinions, the factors listed in 20 C.F.R. § 404.1527 (d)(2) ***must*** be considered (emphasis added). *Id.*

In *Goatcher v. U.S. Department of Health & Human Services*, the Tenth Circuit remanded the case because the "ALJ failed to apply the correct legal standards in weighing the opinion of the appellant's treating physician." *Goatcher v. U.S. Department of Health & Human Services*, 52 F. 3d 288, 289 (10th Cir. 1995). The Tenth Circuit found that an ALJ ***must*** consider the ***specific factors*** listed in 20 C.F.R. § 404.1527 (d) in determining the weight given to any medical evidence (emphasis added). *Id.* at 290.

The Fifth Circuit followed the findings in *Clark* and *Goatcher* in *Newton*, stating that "an ALJ is required to consider ***each*** of the § 404.1527 (d) factors before declining to give any weight to the opinions of the claimant's treating specialist (emphasis added)." *Newton v. Apfel*, 209 F.3d 448, 456 (5th Cir. 2000).

Similarly, in *Prosch*, Eighth Circuit Judge Lay's dissenting opinion found that rejecting the treating doctor's opinion based solely on factors 3 and 4 was insufficient. *Prosch v. Apfel*, 201 F.3d 1010, 1116 (8th Cir. 1999). Circuit Judge Lay explains that "the ALJ and the majority have failed to consider the language in Social Security Ruling 96-2p" by failing to consider factors (1), (2) and (5) in rejecting the opinion of the treating doctor. *See Id.*

In the present matter, the Eleventh Circuit held that the treating source's opinion was inconsistent with the evidence in the entirety, therefore the ALJ was entitled to reject the treating source's opinion. The court failed to follow the standards set out in 20 C.F.R. § 404.1527(d) in evaluating the weight given to the

treating specialist. The Court relied on only one of the factors, factor (4), listed in 20 C.F.R. § 404.1527(d) to discredit the opinion of the treating specialist.

Following the other circuits and the SSR, the opinion of Dr. Mulliken, petitioner's treating physician, should not have been completely rejected by the ALJ. In the given matter, Dr. Mulliken met four of the five factors. Dr. Mulliken maintained an examining relationship, had a long term treatment relationship, his opinion was supported by the medical diagnosis of petitioner, and Dr. Mulliken is a specialist.

Factor one is met by Dr. Mulliken treating petitioner from August 4, 1984 through June 1, 2000 (Pet. App. 11, 20). Factor two is met by Dr. Mulliken not only examined petitioner but performed numerous surgeries on her to address her impairments (Pet. App. 11-12). Factor three is met by the medical diagnosis of petitioner being Klippel Traunary Syndrome (KTS), which is a "rare congenital anomaly characterized by unilateral limb overgrowth, venous varicosities, and capillary malformations (port wine stains) of the affected limb or limbs." Erin E. Huiras, Cheryl J. Barnes, Lawrence F. Eichenfield, Andrew N. Pelech, and Beth A. Drolet, *Pulmonary Thromboembolism Associated with Klippel-Trenaunay Syndrome*, Pediatrics, October 1, 2005, at 1016. KTS varies in degrees of severity with surgical operations being treatment for the most severe cases. *See* Jack Hirsh, Stuart D. Gould, John M. Spandorfer, *Unilateral Leg Swelling: Clues to Cause and Ways to Treat*, Patient Care, February 1, 2006, at 38. Petitioner has a severe form of KTS as demonstrated through the numerous amounts of surgeries she has undergone. Factor five is completed by Dr. Mulliken being a specialist in the field of vascular birthmarks/ hemangiomas and malformations (Pet. App. 11).

By meeting the majority of these factors, Dr. Mulliken's opinion is entitled to substantial weight. The Eleventh Circuit found that since the ALJ stated reasons such as the testimony of the petitioner, petitioner's daily activities and the other medical evidence was adequate to reject the opinion of the Dr. Mulliken.

(Pet. App. 3-4). Only factor (4) inconsistency with the record in its entirety was focused on by the ALJ as cause to reject the opinion of the treating specialist. Using one factor to completely reject the opinion of the treating doctor contradicts the decisions made in three other Circuit Courts.

In sum, the court of appeal's decision misconstrues the evaluation process of the 20 C.F.R. § 404.1527(d) factors, creates a conflict with decision in three other circuits, and invalidates the Social Security Rulings. Accordingly, review by this Court is warranted.

**B. The court of appeals' construction of 20 C.F.R. § 404.1527 has significant public policy implications regarding the evaluation process of impairments that stem from rare diseases.**

Rare, unique disorders present a situation to Social Security Administration that has not been adequately addressed by regulations and case law. A rare disease is defined as "a disease or condition affecting fewer than 2000,000 persons in the United States." *See NIH Launches Clinical Studies Nationwide to Investigate Rare Diseases*, NIH News National Institute of Health, (May 5, 2006) <http://www.nih.gov/news/pr/may2006/ncrr-05.htm>. Approximately 6,000 rare disorders have been identified in the United States affecting about 25 million Americans. *See Id.* Rare diseases are not taken into consideration in determining the method of evaluating impairments for Social Security Disability Insurance Benefits.

Social Security publishes Listing of Impairments that outlines impairments that are considered disabling. The Listings provide a description of various physical and mental illnesses and abnormalities. *See* 10 CFR pt. 404, subpt. P, App. I (pt. A). There are 125 impairments defined in the adult listings. *See Id.* The listings are divided into body system categories which are: musculoskeletal, special senses and speech, respiratory, cardiovascular, digestive, genitor-urinary,

hemic and lymphatic, skin, and endocrine. *See Id.* Four groups of listings are not categorized by the body system: multiple body system impairments, neurological impairments, neurological impairments, mental disorders, and malignant neoplastic diseases. *See Id.* For an impairment to meet a listing, the claimant must show that the impairment meets all the specified medical criteria. *Sullivan v. Zebley*, 110 S.Ct. 885 (1990).

If a claimant's impairment does not meet the Listings, the claimant can qualify for benefits through demonstrating that her unlisted impairment, or combination of impairments, is equivalent to a listed impairment. 20 CFR § 404.1520(e) and 20 CFR § 416.926(a). The claimant demonstrates this equivalency through showing medical findings equal in severity to all the criteria for the one most similar listed impairment. *See Id.* If an adult's impairment meets or equals the listing, the claimant is presumed disabled. *See Bowen v. Yuckert*, 482 U.S. 137, 141 (1987).

All illnesses, abnormalities, and impairments that can be disabling are not covered by the Listings. *Sullivan v. Zebley*, 110 S. Ct. 885, (1990). "The equivalence analysis excludes claimants who have unlisted impairments, or combination of impairments, that do not fulfill all the criteria for any one listed impairment." *Sullivan v. Zebley*, 110 S. Ct. 885 (1990).

Rare diseases are not among the most "frequently diagnosed" impairments, therefore rare diseases are excluded from the listings. The categories in the Listings are narrowly tailored and fail to include rare diseases that by their nature are unusual. People with rare diseases are likely to have to continue past the listings evaluation to the determination of residual functional capacity.

**1. Step Three Evaluation of [illegible] diseases requires a significant amount of weight be given to the opinion of a specialist.**

When an impairment does not meet or equal the Listing, the ALJ makes a finding about the claimant's residual functional capacity (RFC) "based on all the relevant medical and other evidence" in the claimant's case record. *See* 20 C.F.R. § 404.1520(e). Other evidence may include descriptions of the claimant's "limitations that go beyond the symptoms, such as pain, that are important in the diagnosis and treatment" of claimant's medical condition. *See* 20 C.F.R. § 404.1545(a). Observations by the treating or examining physician regarding the claimant's limitations and observations made "during formal medical examinations" are all considered in determining the claimant's RFC. *See Id.* These observations and descriptions along with the medical records are considered by the ALJ in evaluating to what degree the claimant's impairments keep her from performing work activities. *See Id.*

Evaluating the medical evidence and medical opinions regarding claimant's limitations in cases where the impairment is from a rare disease presents a unique situation. Rare diseases present claims that a general practitioner or consultant is not adequately trained or equipped to evaluate. People with rare diseases "often must travel long distances to visit the few doctors knowledgeable about their illnesses." *See* Carlos Rados, *Orphan Products: Hope for People with Rare Diseases*, FDA Consumer, November-December 2003. The inadequate training of general practitioners or consultants in the areas of rare diseases makes their opinion of the limitations of the person suffering from a rare disease insufficient. Rare diseases are not seen often and in general, non-specialist physicians lack exposure to the intricate complexities of such diseases.

A specialist in the medical arena of the specific rare disease is the best trained and has sufficient exposure to the intricacies of the disease in order to formulate an opinion of the physical and or mental limitations that a person diagnosed with such disease suffers. While a general practitioner or consultant lacks the ability to understand and fully treat rare diseases, a specialist is in a position to evaluate the needs and treat the complications associated with rare diseases.

In weighing the opinions given regarding the claimant's limitation, a specialist who understands the complexities of the rare disease is necessary and his/her opinion should be given a great amount of deference.

**2. Klippel-Trenaunay Syndrome is a rare disease that does not meet the listings, therefore the opinion of the specialist should have been given significant weight.**

The National Institute of Health Office of Rare Diseases (NORD) lists Klippel-Trenaunay Syndrome (KTS) as a rare disease. "KTS is a rare congenital anomaly characterized by unilateral limb overgrowth, venous varicosities, and capillary malformations (port wine stains) of the affected limb or limbs." Erin E. Huiras, Cheryl J. Barnes, Lawrence F. Eichenfield, Andrew N. Pelech, and Beth A. Drolet, *Pulmonary Thromboembolism Associated with Klippel-Trenaunay Syndrome*, Pediatrics, October 1, 2005, at 1016. "Large venous malformations such as those observed in KTS are rare, and many physicians are unfamiliar with the potential complications, which include hypercoagulability, thrombosis, and pulmonary embolism." *See Id.* Treatment of KTS typically consist of compression stockings to reduce swelling and "orthopedic surgery is recommended only in severe cases of leg-size discrepancy due to a malformed bony architecture." Jack Hirsh, Stuart D. Gould, John M. Spandorfer, *Unilateral Leg Swelling: Clues to Cause and Ways to Treat*, Patient Care, February 1, 2006, at 38.

KTS is an example of a rare disease that does not meet or equal the Listing of Impairments. Therefore, an evaluation of disability for a person diagnosed with KTS stems on the weight of the evidence in the entirety, which includes all medical evidence, and description and observations of claimant's limitations.

In the present case, petitioner was diagnosed with KTS, capillary-venous-lymphatic malformation of the right lower extremity and underwent numerous surgeries beginning in

1986. (Pet. App. 11). Dr. Mulliken performed these surgeries, which include: knee disarticulation with contouring stump; debulking of the right buttock and above the right knee amputation; shortening, right below-knee amputation of the stump; contour excision of the right buttock and upper thigh; excision of the infected wound in her right thigh; contour resection, overgrown tissue, right upper buttock, resection, pedunculated lymphatico-venous mass, right perineum (Oet. App. 11-12). As demonstrated through the number of surgeries that petitioner has undergone, petitioner suffers from an severe case of KTS.

Like other rare diseases, people diagnosed with KTS require specialist to treat their conditions. With such a severe case as petitioner's, a specialist is essential. Due to the complexity of KTS and the severity of petitioner's condition, a specialist would be in the best position to evaluate claimant's limitations and give a well-founded opinion and description of them. In cases of rare diseases, such as KTS, rejecting the opinion of a specialist fails to recognize the uniqueness and the specificity of knowledge require to understand the complexities of these disorders.

In sum, by rejecting the opinion of a specialist in a claim involving a rare disease, the court of appeals' decision conflicted with public policy that recognizes the importance of a specialist in treating and being knowledgeable about rare diseases and their affect on claimants' limitations. Accordingly, review by this Court is warranted.

## CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

Anthony R. Reeves
*Counsel for Petitioner*

JUNE 2006

*APPENDIX*

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 05-12724
Non-Argument Calendar

D.C. Docket No. 03-00523-CV-FTM-33-SPC

FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
NOVEMBER 17, 2005
THOMAS K. KAHN
CLERK

NATALIE KERWICK,

Plaintiff-Appellant,

versus

COMMISSIONER OF SOCIAL SECURITY,

Defendant-Appellee.

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Appeal from the United States District Court
For the Middle District of Florida

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**(November 17, 2005)**

Before BIRCH, BLACK, and BARKETT, Circuit Judges.

PER CURIAM:

Natalie Kerwick, a 24-year old high school graduate, appeals the district court's order affirming the Commissioner's denial of her application for Childhood Disability Benefits through deceased wage-earner John Kerwick, pursuant to 42 U.S.C. § 405 (g). Kerwick asserts the Administrative Law Judge (ALJ) erred in failing to accord controlling weight to Dr. John B. Mulliken's opinion. We affirm.

## I. DISCUSSION

We must determine whether the Commissioner's decision is supported by substantial evidence and based on proper legal standards. *Crawford v. Comm'r of Soc. Sec.*, 363 F.3d 1155. 1158 (11th Cir. 2004). "Substantial evidence is . . . such relevant evidence as a reasonable person would accept as adequate to support a conclusion." *Id.* (citation omitted). "' Even if the evidence preponderates against the Commissioner's findings, we must affirm if the decision reached is supported by substantial evidence." *Id.* At 1158-59 (citation omitted). We "review de novo the legal principles upon which the Commissioner's decision is based." *Moore v. Barnhart*, 405 F.3d 1208, 1211 (11th Cir. 2005).

A claimant bears the burden of establishing disability. *Jones v. Apfel*, 190 F.3d 12224, 1228 (11th Cir. 1999). Social security regulations provide a five-step sequential process to evaluate whether a claimant has proven she is disabled. *See* 20 C.F.R. § 416.920(a). At the fourth step, the ALJ makes a determination of the claimant's Residual Functional Capacity by considering the claimant's ability to sit, stand, walk, lift, carry, push, pull, reach, handle, stoop, crouch, and other work-related physical demand. *Id.* § 404.1545(b).

Social security regulations also provide guidelines for the ALJ to use when evaluating medical opinion evidence. *Id.* § 404.1527. The ALJ considers many factors when weighing medical opinions, including the examining relationship, the

treatment relationship, whether, an opinion is amply supported, whether an opinion is consistent with the record, and a doctor's specialization. *Id.* § 404.1527(d). In social security disability benefits cases, generally, the opinions of examining physicians are given more weight than non-treating physicians, and the opinions of specialists (on issues within their areas of expertise) are given more weight than non-specialists. *See* § 404.1527 (d) (1)-(2), (5).

A treating physician's testimony "'must be given substantial or considerable weight unless good cause is shown to the contrary.'" *Crawford*, 363 F.3d at 1159 (citation omitted). We have "concluded 'good cause' exists when the: (1) treating physician's opinion was not bolstered by the evidence; (2) evidence supported a contrary finding; or (3) treating physician's opinion was conclusory or inconsistent with the doctor's won medical records." *Phillips v. Barnhart*, 357 F.3d 1232, 1240-41 (11th Cir. 2004). An ALJ does not need to give a treating physician's opinion considerable weight if the claimant's own testimony regarding her daily activities contradicts that opinion. *Id.* at 1241. However, the ALJ must clearly articulate reasons for giving less weight to the treating physician's opinion. *Phillips*, 357 F.3d at 1241.

Additionally, the opinion of a specialist is generally entitled to more weight than the opinions of other non-specialists. *See* 10 C.F.R. § 404.1527(d)(5). However, the ALJ must "always consider the medical opinions in [the] case record together with the rest of the relevant evidence. . . receive[d]." *Id.* § 404.1527(b). While specialists "generally" are entitled to more weight, when there are internal inconsistencies, the specialist's opinion deserves less deference. *See Guilliams v. Barnhart*, 393 F.3d 798, 803 (8th Cir. 2005).

The ALJ accorded little weight to the opinion of Dr. Mulliken, a treating physician and a specialist, finding Dr. Mulliken's opinion was inconsistent with the weight of the record in its entirety. Substantial evidence supports this conclusion. The ALJ noted Dr. Mulliken opined Kerwin could (1) sit for three hours; (2) stand or walk for 2 hours; (3)

occasionally lift up to 20 pounds; (4) grasp, push, and pull with no limitation; and (5) bend and squat, but not crawl or climb or use her feet repetitively. The ALJ pointed out Dr. Mulliken's opinion Kerwick could not sit more than three hours or stand for more than two hours is contradicted by Kerwick's high school attendance, where she sat for nearly seven hours a day, and past employment, where she worked eight hours a day. In high school, Kerwick sat in a classroom 42 minutes or every hour, 7 times a day, 5 days a week. Kerwick was active while working in child care, sitting and standing eight hours a day. Also, she successfully performed clerical work at her uncle's office for a month.

Dr. Mulliken's opinion is also inconsistent with other medical opinions in the record. The ALJ examined evidence from multiple medical sources- Dr. Woletsky, a treating pediatrician who saw Kerwick about four or five time per year; Dr. Seo, a consulting physician; Dr. Smith, a consulting orthopedic surgeon; and Dr. Buonocore, a state agency medical consultant. Evidence from these sources support a finding Kerwick is able to sit without diffculty for up to six hours.

Further, Dr. Mulliken's opinion is inconsistent with Keriwck's own testimony. Kerwick acknowledged she could sit for a couple of hours, then stand for an hour. Kerwick testified she could drive a car, and help cook and clean at home, Also, in the past, Kerwick participated in a gym class and in the Special Olympics.

## II. CONCLUSION

In sum, the ALJ articulated several reasons for giving less weight to Dr. Mulliken's opinion. Thus, we conclude the ALJ's determination that Dr. Mulliken's opinion should be given little weight is supported by substantial evidence.

**AFFIRMED**

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCUIT**

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**No. 04-12724-EE**

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FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
JAN 18 2006
THOMAS K. KAHN
CLERK

NATALIE KERWICK,

Plaintiff-Appellant,

versus

COMMISSIONER OF SOCIAL SECURITY,

Defendant-Appellee.

---

On Appeal from the United States District Court for the
Northern District of Florida

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BEFORE: BIRCH, BALCK, and BARKETT, Circuit Judges.

PER CURIAM:

The petition(s) for rehearing filed by appellant, Natalie Kerwick is DENIED.

ENTERED FOR THE COURT

"s/ Susan H. Black"
UNITED STATE CIRCUIT JUDGE

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
FORT MYERS DIVISION

NATALIE KERWICK,

Plaintiff,

vs. Case No. 2:03-cv-5230FtM-33SPC

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

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**ORDER**

This matter comes before the Court on Magistrate Judge Sheri Polster Chappell's Amended Report and Recommendation (Dec. #12) filed on February 11, 2005, recommending that the decision of the Social Security Commissioner denying her application for a period of childhood disability and disability insurance benefits be AFFIRMED. The Plaintiff filed an Objection to the Report and Recommendation (Doc. #13) on February 22, 2005.

After conducting a careful and complete review of the findings and recommendations, a district judge my accept, reject or modify the magistrate judge's report and recommendation. 20 U.S.C. § 636 (b)(1); *Williams v. Wainwright*, 681 F.2d 732, 732 (11th Cir. 1982), cert. denied, 459 U.S. 1112 (1983). A district judge "shall make a de novo determination of those portions of the report of specified proposed findings or recommendations to which objection is made." 28 U.S.C. § 636 (b)(1)(C). This requires that the district judge "give fresh consideration to those issues to which specific

objection has been made by a party." *Jeffrey S. by Ernest S. v. State Bd. Of Educ. Of Ga.*, 896 F.2d 507, 512 (11th Cir. 1990)(quoting H.R. 1609, 94th Cong., § 2 (1976)). The district judge reviews legal conclusions de novo, even in the absence of an objection. *See Cooper-Houston v. Southern Ry. Co.*, 37 F.3d 603, 604 (11th Cir. 1994).

After conducting a careful and complete review of the findings, conclusions and recommendations, and giving de novo review to matters of law and those matters to which objections were filed, the Court accepts the factual findings and legal conclusions of the magistrate judge, and the recommendation of the magistrate judge regarding the motions.

Accordingly, it is now

**ORDERED, ADJUDGED,** and **DECREED:**

United States Magistrate Judge Sheri Polster Chappell's Amended Report and Recommendation (Doc. #12) is **ACCEPTED** and **APPROVED** and Plaintiff's Objection to the Report and Recommendation is **OVERRULED.**

**DONE** and **ORDERED** in Chambers in Fort Myers, Florida, this 1st day of March, 2005.

"s/Virginia M. Hernandez Covington"
Virginia M. Hernandez Covington
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
FORT MYERS DIVISION

NATALIE KERWICK,

Plaintiff,

vs. Case No. 2:03-cv-5230FtM-33SPC

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

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**REPORT AND RECOMMENDATION**[1]

This matter comes before the Court on the Plaintiff Natalie Kerwick's appeal to the district court from a final decision of the Commissioner of Social Security denying her application for a period of childhood disability and disability insurance benefits. (Doc. #1). The Commissioner filed a response (Doc. #4) on October 28, 2003. The plaintiff filed her memorandum of law on January 20, 2004, (Doc. #8). The Commissioner filed its memorandum of law on February 6, 2004, (Doc. #9). Thus, this appeal is now ripe for determination.

**FACTS**

*Procedural History*

[1] This Report and recommendation addresses only the issues brought up for review by the District Court pursuant to 28 U.S.C. § 405(g).

On October 6, 1998, the Plaintiff filed her application for childhood disability benefits under Sections 202(d) and 223 of the Social Security Act (the Act) alleging disability since her birth on February 8, 1998. (Tr. 122). The application was denied initially. The Plaintiff timely filed a request for reconsideration on May 5, 1999, (Tr. 114-115). The Social Security Administration affirmed its decision and the Plaintiff appealed (Tr. 116-120). The Plaintiff timely filed a request for hearing (Tr. 118-120). A hearing was held on June 7, 2000, before the Honorable Ruben Rivera, Administrative Law Judge (ALJ)(Tr. 71-91). The plaintiff was assisted by attorney, Bart Nadel. On August 14, 2000, the ALJ issued an Order denying benefits to the Plaintiff (Tr. 2232-234). The Plaintiff appealed the ALJ's decision through the Appeal's Council. Upon review, on February 2, 2003, the Appeals Council issued an order remanding the case back to the ALJ (Tr. 250-253).

The case was subsequently heard on April 12, 2002, before the Honorable Ruben Rivera, Jr. (tr. 71-90). A supplemental hearing was held on June 6, 2002, (Tr. 91-106). On August 12, 2002, the ALJ issued an unfavorable decision (tr. 14-26). The Plaintiff filed a request for review with the Appeals Council on September 3, 2002. The request for review was denied on August 22, 2004, (Tr. 6-8) making the ALJ's decision of August 12, 2002, the final decision of the Commissioner. Pursuant to 42 USC § 405(g), the Plaintiff filed the instant case and the case is now ripe for review.

*Plaintiff's History*

At the time of the administrative hearing, the Plaintiff was twenty-one (21) years old (Tr. 18). The Plaintiff will have reached the age of twenty-two (22) by February 8, 2003, and therefore, pursuant to 20 CFR § 404.1569 is considered to a "younger individual" (tr. 26). The Plaintiff has a high school education and has no past relevant work (Tr. 23, 124). The Plaintiff alleges that disability began at birth on February 8,

1981, due to capillary-venous-lymphatic-malformation[2] of the lower extremity (Klippel-Trenaunay Syndrome)[3](Tr. 122, 130, 160). It resulted in the amputation of the right leg below the knee (Tr. 168). The Plaintiff required multiple surgeries through the years to address infections, contouring of the stump and debulking procedures on the right buttock and upper thigh (Tr. 153-169).

The Plaintiff briefly worked in a day care where she cared for children from age one (1) though five (5) years old (Tr. 56). She stated that she would work from 8:30A.M. to sometimes 6:00P.M. (Tr. 56, 58). She later began another job relating to young children as a teacher's aide in a Collier County elementary school (Tr. 60). She stayed in this position for approximately 3 to 4 months (Tr. 60). The Plaintiff testified that these were the only two (2) jobs that she held and she did not seek other employment after leaving the elementary school (Tr. 61). She states that working with the young children was difficult due to the high volume of walking (Tr. 61).

While she attended high school, the Plaintiff was able to attend seven classes during the day which were 42 minutes long (Tr. 65), however she indicated she was frequently absent due to illness (Tr. 65, 147). She participated in all gym activities, and physical activities except for jumping jacks and squat thursts (Tr. 88). She was able to walk around school, however, if she needed to go to another floor she would often use the elevator (Tr. 75). She states that often times she would "run herself down" if she was doing a lot of walking and the stump would bleed, swell, and she would develop a high fever. The

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[2] Capillary-venous is defined as one of the minute vessels that convey blood from a capillary network into small veins. Lymphatic capillary is defined as one of the smallest lymphatic vessels. Malformation is a deformity or abnormal shape or structure.

[3] Klippel-Trenaunay Syndrome is characterized by a patchy pot-wine stain on an extremity that overlies a combined venous and lymphatic malformation with associated bony enlargement. Http://www.kidsplastsurg.com/klippel.html accessed January 27, 2005.

Plaintiff testified that she used a prosthesis but the appliance often rubbed against the stump and malfunctioned (Tr. 149).

When asked at the hearing about her ability to sit for any length of time, the Plaintiff testified that excessive sitting also affected her due to the malformation on her right buttock and hip (Tr. 64). She further testified that sitting for a long time would cause bleeding on her buttock and hip (Tr. 64). However, she indicated that she could sit for a couple of hours if she was able to squirm and not stay in one spot (Tr. 64). When asked at the hearing about her ability to stand for any given length of time, she stated that she could stand for about an hour if "pushing herself" but could go a little longer is she was able to sit in between (Tr. 64).

At hearing, the Plaintiff testified that she could cook "a little bit", cleans her own room, and can throw laundry into the washing machine (Tr. 85). She has a driver's license and drives herself to the store (Tr. 79) but cannot drive for long distances in the car. She is able to walk on smooth surfaces for thirty (30) minutes and lift 10 to 15 pounds. Additionally, she performs sedentary duties such as watching television, listening to the radio and completing homework (Tr. 144).

*Medical History*

The Plaintiff was born on February 8, 1981, with capillary venous lympathic malformation of the right lower extremity. On August 4, 1984, Dr. J.B. Mulliken[4] performed a surgery for subtotal excision of the skin and subcutaneous malformation of the right calf and dorsum foot (Tr. 186). Dr. Mulliken believed that a high amputation was inevitable (Tr. 168). Because she

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[4] Dr. John B. Mulliken is an associate professor of surgery at Harvard Medical School and Fellow of the American College of Surgeons. Dr. Mulliken is on staff at the Children's Hospital and Brigham and Women's Hospital in Boston, Massachusetts (Tr. 230). Dr. Mulliken co-authored a book on Vascular Birthmarks, Hemangiomas and Malformations which included a picture of the Plaintiff to depict massive Klippel-Trenaunay syndrome (Tr. 231).

continued to have problems with her right leg, Dr. Mulliken performed a right knee disarticulation[5] with contouring of the stump on June 5, 1984.

On August 23, 1985, the Plaintiff underwent a debulking[6] procedure of the right lower above the knee amputation (Tr. 164). The Plaintiff was diagnosed with Klippel-Trenaunay Syndrome combined with veno-lymphatic capillary malformation of the right lower extremity (Tr. 164). Dr. Mulliken indicated that the Plaintiff underwent multiple procedures for recurrent infections (Tr. 164).

On July 17, 1989, the Plaintiff developed breakdown of the amputated stump which prevented her from wearing her prosthesis (Tr. 165). Dr. Mulliken diagnosed the only alternative was to shorten the femur and re-sect some of the abnormal skin (Tr. 165). Subsequently, on November 4, 1993, the plaintiff underwent a wide contour excision of the right buttock and upper thigh (Tr. 160) due to a difficulty in sitting and its large size. At that time, he noted in his report that the Plaintiff was able to ambulate with the prosthesis (Tr. 160). On March 28, 1994, Dr. Mulliken performed an excision on an infected wound (Tr. 159). Dr. Mulliken opined that she had resistant pseudomonas (Tr. 159).

On February 8, 1998, at the age of seventeen (17), the Plaintiff participated in physical therapy with Ellen Almodovar, P.T. while attending high school (Tr. 200). Mrs. Almodovar stated that the Plaintiff ambulated with a prosthetic independently throughout the school and without an assistive device (Tr. 2 ). She stated that the Plaintiff was able to negotiate steps independently, occasionally using the wall for balance (Tr. 200). Her muscle strength in bilateral lower extremities was good to normal (tr. 200). Furthermore, she exhibited decreased passive range of motion in right hip straight

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[5] Disarticulation is defined as an amputation through a joint. *Taber's Cyclpedic Medical Dictionary*, 762 (Donald Menes, M.D. ed., 19th ed. F.A. Davis 1997)(herinafter *Taber's*).

[6] Debulking is a surgical procedure to remove a large portion of a tumor when complete excision is not possible.

leg raise only, however all else is within functional to normal limits. Mrs. Almodovar indicated that the Plaintiff participated in physical education classes but refused to come to the physical therapy consult sessions (Tr. 200). She explained that since the Plaintiff was independent at school and no reports of difficulty were made, physical therapy was not recommended for the following year (Tr. 200).

On March 22, 1999, the Plaintiff presented to Dr. K. Seo complaining of difficulty standing, walking (unable to walk more than 2 blocks), swelling of the right thigh and frequent fevers. Dr Seo noted the difficulty walking and maneuvering with and without the prosthesis (tr. 214). However, Dr. Sea indicated that the upper extremities showed normal range of motion or the shoulder joints, elbow joints and wrist joints (Tr. 214). A physical examination of the Plaintiff revealed swelling of the right thigh due to hemangiomatas lesions (Tr. 20, 215). Muscle strength in the left leg was grade 5/5 and the right leg was 3/5. Dr. Seo opined that, at that time, the Plaintiff was able to sit without much difficulty, was able to stand less than one hour in an eight (8) hour working period, was able to walk couple blocks and lift/carry less than 10 lbs (Tr. 215).

On July 22, 1999, the Plaintiff presented to Dr. Milton M. Smith, a State Agency medical consultant, at the request of the Division of Disability Determinations (Tr. 216). Upon examination, the Plaintiff was found to have a full range of motion in the upper extremities, grip strength was normal, no motor or sensory deficits, biceps and triceps were present and equal bilaterally, and ankle and knee jerk reflexes were present and equal bilaterally. Examination of the Plaintiff's right hip revealed minimal range of motion with no redness, swelling, increased warmth or tenderness (tr. 20, 216). Dr. Smith's impression was that the Plaintiff's physical examination was entirely normal except for the right above knee amputation (tr. 218). He further noted that there was marked functional disability to standing, walking, twisting and carrying (Tr. 218).

On August 23, 1999, Dr. Anthony Buonocore, a state agency medical consultant, completed a Residual Functional

Capacity Assessment (RFC). The Plaintiff was found to be capable of lifting/carrying ten (10) lbs. occasionally, less than 10 lbs. frequently, stand and/or walk at least 2 hours in an 8 hour workday, and sit for 6 hours in an 8 hour workday (tr. 219). No limitations were placed on pushing and or pulling (tr. 219). The Plaintiff can occasionally climb a ramp or stairs, balance and stoop.

*Administrative Law Judge's Decision*

After reviewing the entire record, the ALJ determined that the Plaintiff meets the non-disability requirements for Childhood Disability Benefits established in Section 202(d) of the Social Security Act with the exceptions noted in 20 C.F.R. § 404.355(B)(2)[7]. The ALJ found that the Plaintiff had not engaged in substantial gainful activity since the alleged onset of disability (tr. 25).

After reviewing the medical record, the ALJ determined that the Plaintiff did have an impairment or combination of impairments considered "severe" based upon the requirements outlined in the Regulations, 20 C.F.R. 404.1520(b) (Tr. 25). However, the medically determinable impairments do not meet or medically equal one of the listed impairments in Appendix 1, Subpart P, Regulation No. 4 (Tr. 25).

Upon careful consideration of the medical opinions offered into the record, the ALJ found that the Plaintiff has the residual functional capacity to perform a full range of light work

[7] As outlined by the ALJ, an individual is entitled to Childhood Benefits on the earnings of record of an insured person who is entitled to old age or disability benefits or who has dies if (a) you are the insured person's child, based upon a relationship described in 20 C.F.R. § 404.355 or (b) you are dependent on the insured, as defined in 20 C.F.R. § 404.360 and § 404.365 (c) you apply for benefits (d) you are unmarried (e) you are under the age of 18 or you are 18 years old or older and have a disability that began before becoming 22 years old, or you are 18 years or older and qualify for benefits as a full time student as described in 20 C.F.R. § 404.367 and § 404.369. The ALJ concluded that the Plaintiff meets the non-disability requirements for Childhood Disability Benefits.

reduced by non-exertional limitations, secondary to right leg amputation resulting in the need to alternate sitting and standing during the course of an eight (8) hour workday (Tr. 26). He further found that the Plaintiff's exertional limitations do not allow her to perform the full range of light work. However, using the Medical-Vocational Rule 202.20 and 201.27 as a guideline and the testimony of the vocational expert, it was determined that a significant number of jobs exist in the national economy that the Plaintiff can perform (Tr. 26). Therefore, he found that the Plaintiff is not under a "disability" as defined in the Social Security Act and thus, not entitled to Childhood Disability under Sections 202 (d) and 223 (Tr. 27).

## STANDARD OF REVIEW

"The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence shall be conclusive." 42 U.S.C. 405(g). the court "may not decide the facts anew, re-weigh the evidence or substitute [the court's] judgment for that of the [Commissioner]." *Bloodsworth v. Heckler*, 703 F.2d 1233, 1239 (11th Cir. 1983). The court will review the decision to determine whether the correct legal standards were applied. *Martin v. Sullivan*, 894 F.2d 1520, 1529 (11th Cir. 1990). The court must review the record as a while and determine whether the decision was reasonable and supported by substantial evidence. Substantial evidence is more than a scintilla, and is relevant such that a reasonable person would accept the evidence as support for the decision. *Richardson v. Perales*, 402 U.S. 389, 401 (1971). "even if the evidence preponderates against the [Commissioner's] finding, [the court] must affirm if the decision reached is supported by substantial evidence." *Martin*, 894 F.2d at 1529 (*citing Sewell v. Bowen*, 792 F.2d 1065, 1067 (11th Cir. 1986).

## DISCUSSION

When reviewing the final decision of the Commissioner, the court must evaluate: (1) whether the ALJ followed the five-step sequential evaluation found in 20 CFR § 404.1520 to determine whether or not the individual was disabled, and (2) whether the ALJ's decision was supported by substantial evidence.

*(1) Whether the ALJ Followed the Five-Step Sequential Evaluation*

To determine whether a claimant qualifies for Social Security disability benefits, the ALJ must follow a five step sequential evaluation process set forth by 20 C.F.R. 404.1520. *Johnson v. Barnhart*, 268 F. Suppr.2d 1317, 1324 (11th Cir. 2002). If a determination as to the claimant's disability can be made at one stage, it is not necessary for the ALJ to move on to the next step in the evaluation. *McCruter v. Bowen*, 791 F.2d 1544, 1546 (11th Cir. 1986).

The first step in the evaluation process is to consider what employment the claimant has had, and whether the claimant has been participating in the substantial gainful activity. Gainful activity is defined as work that one does for pay or profit, whether or no the profit is realized. 20 C.F.R. §404.1520. Substantial gainful activity is defined as work that involves significant physical or mental activities. Id. The claimant is not disabled if he/she has been working. Johnson, 268 F.Supp.2d at 1324. Here, the ALJ determined that since the alleged onset date of disability, the Plaintiff has not engaged in substantial gainful activity (Tr. 25).

The second step is to consider the severity of the claimant's impairment, taking into account the duration of the impairment and impairments in combination. Here, the ALJ must decide whether the impairment imposes a limit on the claimant's physical or mental ability to participate in basic work activities. *Crayton v. Callahn*, 120 F.3d 1217, 1219 (11th Cir. 1997). The ALJ concluded that the Plaintiff's impairments consisting of status post above the knee and mid thigh amputation of the right leg, secondary to capillary-venous-lymphatic malformation and

residuals of status post multiple corrective surgeries and contour resections are "severe" within the meaning of the Regulations (Tr. 19, 25).

The third step in the evaluation process is to consider the severity of the impairment as compared to a previous listing of impairments that has been recognized as disabling. Should the ALJ determine that the impairment meets or equals in severity a listed impairment, the claimant is presumed to be disabled and entitled to benefits. *Bowen v. New York*, 476 U.S. 467, 471, 106 S.Ct. 2002, 90 L.Ed. 2d 462 (1986). The ALJ stated that while the evidence in the record indicated the plaintiff had severe impairments. The impairments were not severe enough t meet or medically equal one of the impairments listed in Appendix 1, Subpart P, Regulations No. 4 (Tr. 19). The ALJ then moved on to step four.

The fourth step in the evaluation process requires the ALJ to determine the plaintiff's residual functional capacity (RFC) and based on that determination, decide whether the plaintiff is able to return to her/her previous work. *McCruter*, 791 F.2d at 1547. The RFC is defined as the most an individual can do despite the limitations of their disability. 20 C.F.R. § 404.1545. Past relevant work is defined as work performed within the last 15 years or 15 years prior to the onset of disability. 20 C.F.R. § 404.1565(a). the work must have lasted for a long enough time to qualify as gainful activity and to allow the claimant to learn how to do the job. Id. Here, the ALJ determined the Plaintiff did not have any past relevant work (Tr. 26). The ALJ then moved on to Step Five.

At step five, the ALJ must determine based on the claimant's vocational factors, age, education, and work experience that the claimant can perform some other work found in the national economy. *Phillips v. Barnhart*, 357 F.3d 1232, 1239 (11th Cir. 2004). Essentially, the ALJ must determine if there is other work available, in significant numbers, in the national economy is not disabled. Id. If the ALJ determines that the claimant cannot make the transition to

other work, then the ALJ will determine that the claimant is disabled and entitled to benefits. *Id.*

The ALJ employed the use of a vocational expert (VE) to determine if the Plaintiff could perform work in accordance with 20 C.F.R. § 404.20(g) (Tr. 23). The vocational expert was present during the supplemental hearing on June 6, 2002, (Tr. 93-102). Upon review of the Plaintiff's RFC. The VE's testimony and the Medical-Vocational Guidelines, the ALJ concluded that the Plaintiff was capable of performing a significant range of jobs in the national economy as outlined by the vocation expert (Tr. 24, 98-99).

*(2)Whether the ALJ's Decision is Supported by Substantial Evidence*

The court "may not decide the facts anew, reweigh the evidence or substitute its judgment for that of the [Commissioner]." *Bloodsworth*, 703 F.2d at 1239. If the Commissioner's decision is supported by substantial evidence, it should not be disturbed. *Lewis*, 125 F.3d at 1440.

The Plaintiff contends that the ALJ's decision is not supported by substantial evidence because the ALJ failed to lend proper weight to the treating physician's opinions. Specifically, the Plaintiff argues that the Plaintiff's treating physician, Dr. Mulliken, should be accorded substantial weight as opposed to a non-specialist treating physician. The Plaintiff further argues that the ALJ's hypothetical questions regarding the Plaintiff's impairments were inaccurate and thus yielded an inaccurate assessment by the VE.

*a)Whether the ALJ Accorded the Proper Weight to the Opinin of the Treating Physician*

The Plaintiff contends that the ALJ erred in failing to lend substantial weight to the Plaintiff's treating, Dr. Mulliken. The Plaintiff argues that Dr. Mulliken is in the best position to make a determination as to the extent of the Plaintiff's impairments.

It is well established that "the testimony of a treating physician must be given substantial or considerable weight unless "good cause" is shown to the contrary. *Crawford v. Commissioner of Social Security*, 363 F3d 1155, 1159 (11th Cir. 2004) (citing *Lewis*, 125 F.3d at 1440). A treating physician's report "may be discounted when it is not accompanied by objective medical evidence or is wholly conclusory." Crawford, 363 F.3d at 1159 (citing *Edwards v. Sullivan*, 937 F.2d 580, 583-84 (11th Cir. 1991)(holding that good cause existed where the opinion was contradicted by other notations in the physician's own record). The ALJ may not reject medical opinions without offering some explanation. *Holley v. Chater*, 931 F.Supp. 840, 848 (S.D. Fla. 1996)(citing *MacGregor v. Bowen*, 786 F.2d 1050, 1052 (11th Cir. 19986)). Further, the "requisite good cause" necessary to discount a treating physician's opinion cannot be provided solely by the report of a non-examining physician. *Id.* at 848.

Dr. Mulliken began treating the Plaintiff for a congenital defect of capillary-venous-lympathic syndrome when the Plaintiff was approximately 2 ½ years old (Tr. 66, 168) and continued to treat her throughout the years when she had complications with her condition. Clearly, Dr. Mulliken is familiar with the Plaintiff's condition and impairments and is considered her treating physician. Although the Plaintiff testified at hearing in June 2002 that she had seen Dr. Mulliken the previous summer and that she saw him every two years, the record does not include any specific medical evidence from Dr. Mulliken after July 1997 (Tr. 105). A claimant bears the burden of providing evidence that she is disabled within the meaning of the Social Security Act. 42 U.S.C. §423(d)(5)(A); 20 C.F.R. §404.1512.

Upon review of the record in its entirety, the ALJ stated that he accorded little weight to the opinion of Dr. Mulliken, the Plaintiff's treating physician (Tr. 22). As grounds for discounting the opinion, the ALJ stated that Dr. Mulliken's opinion was inconsistent with the weight of the record in its entirety (Tr. 22).

In his 2000 Physical Capacity Evaluation of the Plaintiff, Dr. Mulliken opined that she can stand or walk two (2) hours in an eight (8) hour workday, the Plaintiff can sit three (3) hours in an (8) hour workday, lift 11-20 lbs. occasionally, use her hands for simple grasping, pushing, pulling, and fine manipulation, bend frequently and squat occasionally (Tr. 227-229). However, the ALJ pointed to specifics in the Plaintiff's own testimony to discount Dr. Mulliken's opinion. Specifically, the plaintiff is able to watch television, use the computer, listen to the radio, fish, visit with friends, stand for an hour, lift ten to fifteen pounds, help with cooking, clean her room, and participate in physical education activities (Tr. 21-22).

Further, a Vocational Evaluation report completed by Audrey Ventimiglia at Eastern Suffolk BOCES on December 5, 1995, reflects that the Plaintiff attended school on a regular basis, was enrolled in vocational training for child care, and worked as a babysitter after classes for a five (5) year old child (Tr. 188). The Plaintiff participated in the Special Olympics and won five (5) gold medals in track and field events, including the discus and softball throw and the 25 to 50 meter swim (Tr. 188). The evaluator noted that the Plaintiff demonstrated fine motor dexterity and control and was very methodical (Tr. 189). She worked independently and appeared to enjoy the hands on nature of tasks (Tr. 188).

As further evidence that Dr. Mulliken's opinion should be given little weight, the ALJ noted the Plaintiff's refusal to receive physical therapy, her lack of medication, and the absence of noteworthy treatment after 1997 (Tr. 19-22).

Clearly, based upon the Plaintiff's own testimony, she is capable of successfully participating in sedentary activities. Thus, a determination that the Plaintiff is capable of engaging in sedentary or light work is entirely credible. On that basis, the Court finds the decision of the ALJ is reasonable. He properly stated the requisite good cause and substantial evidence supports his findings. Therefore, the Court will not disturb the findings of the ALJ in regard to the amount of weight given the treating physician.

The ALJ stated that the opinion of Dr. Seo would be accorded probative weight based upon the physician's report (Tr. 22). As grounds, the ALJ points to the examination report dated March 22, 1999. In his report, Dr. Seo indicates that the Plaintiff was able to "sit without much difficulty, able to stand less than 1 hour in an 8 hour working period," and able to walk a couple of blocks and lift/carry less than ten pounds (Tr. 215). He further noted that both upper extremities show normal range of motion of the shoulder joints, elbow joints, and wrist joints (Tr. 214). Muscle strength in both hands and arms is 5/5 (Tr. 214). Dr. Seo placed no limitations on the Plaintiff's ability to sit (Tr. 215) and noted that the Plaintiff does not take medication (Tr. 213). This, the ALJ noted would allow for at least sedentary work for the Plaintiff (Tr. 22). On that basis, the Court find that substantial evidence supports the determination of the ALJ that Dr. Seo's opinions should be given probative weight.

The ALJ stated the opinion of Dr. Ira Wotezky is accorded considerable weight (Tr. 23). In support thereof, the ALJ refres to the fact that Dr. Wotezky saw the Plaintiff in 1983, and last saw her in an examination on March 19, 1999 (Tr. 22). Upon, examination, Dr. Wotezky notes that the Plaintiff was well adjusted, fatigue was not present, and the Klippel Trenaunay Syndrome was asymptomatic (Tr. 205-208). Dr. Wotezky's medical opinion regarding the Plaintiff's ability to work was that the Plaintiff could lift/carry up to 25lbs. and stand/walk up to 2 hours per day. No limitation was placed on sitting, pushing and pulling The ALJ found this assessment consistent with the ability to perform at least sedentary work with the exertional ability to lift and/or carry at the light level (Tr. 23). The ALj found that his opinion accorded considerable weight as it is supported by objective medical findings of record (Tr. 23) and the Court will not disturb this opinion based upon substantial evidence in the record. *Lewis*, 125 F.3d at 1440.

The ALJ further indicates that the Residual Functional Capacity Assessment (RFC) completed by Dr. Anthony Buonocore, a state agency medical consultant, is accorded

considerable weight (Tr. 23, 219-226). As noted previously, Dr. Buonocore opined that the Plaintiff was capable of lifting/carrying ten (10) lbs. occasionally, less than 10 lbs. frequently, stand and /or walk at least 2 hours in an 8 hour workday, sit for 6 hours in an 8 hour work day and no limitations were placed on pushing and/or pulling (Tr. 219). Furthermore, Dr. Buonocore opined that the Plaintiff can occasionally climb a ramp or stairs, balance and stoop. This opinion and the ALJ's determination is supported by the medical evidence and the record as a whole and therefore, will not be disturbed.

*Whether the ALJ's Erred in Relying on the Testimony of the VE*

The ALJ is to determine the Plaintiff's residual functional capacity (RFC) and base on that determination, decide whether the Plaintiff is able to return to his/ her previous wok. *McCruter*, 791 F.2d at 1547. Here, the ALJ determined that the Plaintiff had no past relevant work (Tr. 25). Having that determination, decide the burden shifts to the Social Security Administration to determine if the Plaintiff was capable of performing other work. 20 C.F.R §404.1520(g). Often the Commissioner meets this burden by relying on the grids. *Jones v. Apfel*, 190 F.3d 1224 9C.A.11 Ala. 1999)(citing *Foote v. Chater*, 67 F.2d 1553, 1559 (11th Cir. 1995)). When the claimant cannot perform a full range of work at a given level of exertion or the claimant has non-exertional impairments that significantly limit basic work skills, exclusive reliance on the grids is inappropriate. *Id.* at 1229. In such cases, the Commissioner's preferred methods of demonstrating that the claimant can perform other jobs is through the testimony of a vocational expert (VE). In order for the VE's testimony to constitute substantial evidence, the ALJ must post a hypothetical question which comprises all of the claimant's impairments. *Id.* at 1229.

A vocational expert, Everett Tessmer, PhD., presented testimony at the hearing on June 2, 2002, to help determine whether or not there are a significant number of jobs in the national economy that the Plaintiff could perform given her RFC and vocational factors (Tr. 93-100). The ALJ asked the VE a hypothetical question. Specifically, he asked the VE to consider the person to be 21 years of age with a high school education. The hypothetical person was said to have a valid drivers' license and would be able to drive using the left foot, having a restriction of sitting for no more than two (2) hours at one time, standing no more than one (1) hour at any given time, would be able to sit or stand at least six (6) hours in an eight (8) hour workday, alternating in those positions and with limited lifting of 10 to 20 lbs. (Tr. 96-97). The ALJ then asked whether it would be possible for the hypothetical person to perform the work that the Plaintiff previously performed (Tr. 97). The VE responded that the previous jobs could not be preformed by the Plaintiff based upon the standing and sitting limitations (Tr. 97). The ALJ went further to inquire as to any transferable job skills the Plaintiff would have acquired during her job as teacher's aide, to which the VE testified that she had little if any transferable skills (Tr. 97). Finally, the ALJ inquired as to other kinds of work in the national economy, given the Plaintiff's physical limitations and RFC, that she could perform. The VE testified that there are a variety of positions that she could perform including cashiering (leaning towards the clerical aspect, telephone answering service, order clerk, an/or a classified ad clerk as long as the positions required sedentary exertion (Tr. 98). He also testified that she could perform the duties of a tourist information assistant or a customer service clerk (Tr. 99).

The Plaintiff contends that the ALJ erred in not considering Dr. Mulliken's opinion and her subjective complaints of disabling pain and limitations. For the reasons stated previously, the ALJ discounted Dr. Mulliken's opinion and thus, it was not necessary to consider this further. Given the evidence in the record as a whole, the ALJ found that subjective

complaints of the Plaintiff were not totally credible. Thus, the ALJ was not required to probe further the Plaintiff's unsupported claim in the hypothetical question.

Substantial evidence exists to support the ALJ's hypothetical question and the testimony elicited in response. Consequently, the ALJ concluded that the Plaintiff is capable of performing other work as described by the vocational expert and, therefore, the Plaintiff's argument lacks merit. On that basis, the Court finds that substantial evidence exists to support a finding that the Plaintiff is not disabled within the meaning of the Act.

Accordingly, it is respectfully

**RECOMMENDED:**

The Final Decision of the Commissioner should be **AFFIRMED**.

**DONE AND ORDERED** at Fort Myers, Florida, this 7th day of February, 2005.

"s/ Sheri Polster Chappell"
SHERI POLSTER CHAPPELL
UNITED STATES MAGISTRATE JUDGE

**Statutes and regulations**

**42 USCS § 423(d)**
§ 423. Disability insurance benefit payments

(d) Disability defined.

(1) The term "disability" means--

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1) [42 USCS § 416(i)(1)]), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A)--

(A) An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(B) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Commissioner of Social

Security shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Commissioner of Social Security does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(C) An individual shall not be considered to be disabled for purposes of this title [42 USCS §§ 401 et seq.] if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4) (A) The Commissioner of Social Security shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed an amount equal to the exempt amount which would be applicable under section 203(f)(8) [42 USCS § 403(f)(8)], to individuals described in subparagraph (D) thereof, if section 102 of the Senior Citizens' Right to Work Act of 1996 had not been enacted. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 222(c) [42 USCS § 422(c)], be found not to be disabled. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care

services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security may prescribe.

(B) In determining under subparagraph (A) when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity, the Commissioner of Social Security shall apply the criteria described in subparagraph (A) with respect to services performed by any individual without regard to the legality of such services.

(5) (A) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Commissioner of Social Security may require. An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue)

must be considered in reaching a conclusion as to whether the individual is under a disability. Any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Commissioner of Social Security under this paragraph shall be entitled to payment from the Commissioner of Social Security for the reasonable cost of providing such evidence.

(B) In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Commissioner of Social Security shall consider all evidence available in such individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability. In making any determination the Commissioner of Social Security shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic test, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

(6) (A) Notwithstanding any other provision of this title [42 USCS §§ 401 et seq.], any physical or mental impairment which arises in connection with the commission by an individual (after the date of the enactment of this paragraph [enacted Oct. 19, 1980]) of an offense which constitutes a felony under applicable law and for which such individual is subsequently convicted, or which is aggravated in connection with such an offense (but only to the extent so aggravated), shall not be considered in determining whether an individual is under a disability.

(B) Notwithstanding any other provision of this title [42 USCS §§ 401 et seq.], any physical or mental impairment which arises in connection with an individual's confinement in a jail, prison, or other penal institution or correctional facility pursuantto such individual's conviction of an offense (committed after the date of the enactment of this paragraph

[enacted Oct. 19, 1980]) constituting a felony under applicable law, or which is aggravated in connection with such a confinement (but only to the extent so aggravated), shall not be considered in determining whether such individual is under a disability for purposes of benefits payable for any month during which such individual is so confined.

**20 CFR 404.1508**

§ 404.1508 What is needed to show an impairment.

If you are not doing substantial gainful activity, we always look first at your physical or mental impairment(s) to determine whether you are disabled or blind. Your impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms (see § 404.1527). (See § 404.1528 for further information about what we mean by symptoms, signs, and laboratory findings.)

**20 CFR 404.1527(d)**

§ 404.1527(d) Evaluating opinion evidence.

(d) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are

likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect

to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other

information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

**20 CFR 404.1520**
§ 404.1520 Evaluation of disability in general.

(a) General -- (1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 404.1505.

(2) Applicability of these rules. These rules apply to you if you file an application for a period of disability or disability insurance benefits (or both) or for child's insurance benefits based on disability. They also apply if you file an application for widow's or widower's benefits based on disability for months after December 1990. (See § 404.1505(a).)

(3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.

(4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) of this section and § 404.1560(b).)

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 404.1560©.)

(5) When you are already receiving disability benefits. If you are already receiving disability benefits, we will use a different sequential evaluation process to decide whether you continue to be disabled. We explain this process in § 404.1594(f).

(b) If you are working. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

© You must have a severe impairment. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience. However, it is possible for you to have a period of disability for a time in the past even though you do not now have a severe impairment.

(d) When your impairment(s) meets or equals a listed impairment in appendix 1. If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.

(e) When your impairment(s) does not meet or equal a listed impairment. If your impairment(s) does not meet or equal a listed impairment, we will assess and make a finding about your residual functional capacity based on all the relevant medical and other evidence in your case record, as explained in § 404.1545. (See paragraph (g)(2) of this section and § 404.1562 for an exception to this rule.) We use our residual functional capacity assessment at the fourth step of the sequential evaluation process to determine if you can do your past relevant work (paragraph (f) of this section) and at the fifth step of the sequential evaluation process (if the evaluation proceeds to this step) to determine if you can adjust to other work (paragraph (g) of this section).

(f) Your impairment(s) must prevent you from doing your past relevant work. If we cannot make a determination or decision at the first three steps of the sequential evaluation process, we will compare our residual functional capacity assessment, which we made under paragraph (e) of this section, with the physical and mental demands of your past relevant work. (See § 404.1560(b).) If you can still do this kind of work, we will find that you are not disabled.

(g) Your impairment(s) must prevent you from making an adjustment to any other work. (1) If we find that you cannot do your past relevant work because you have a severe impairment(s) (or you do not have any past relevant work), we will consider the same residual functional capacity assessment we made under paragraph (e) of this section, together with your vocational factors (your age, education, and work experience) to determine if you can make an adjustment to other work. (See § 404.1560(c).) If you can make an adjustment to other work, we will find you not disabled. If you cannot, we will find you disabled.

(2) We use different rules if you meet one of the two special medical-vocational profiles described in § 404.1562. If you meet one of those profiles, we will find that you cannot make an adjustment to other work, and that you are disabled.

**20 C.F.R 404.1545 (a)**
§404.1545(a) Your residual functional capacity.

(a) General—(1) Residual functional capacity assessment. Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. Your residual functional capacity is the most you can still do despite your limitations. We will assess your residual functional capacity based on all the relevant evidence in your case record. (See §404.1546.)

(2) If you have more than one impairment. We will consider all of your medically determinable impairments of which we are aware, including your medically determinable impairments that are not "severe," as explained in §§404.1520(c), 404.1521, and 404.1523, when we assess your residual functional capacity. (See paragraph (e) of this section.)

(3) Evidence we use to assess your residual functional capacity. We will assess your residual functional capacity based on all of

the relevant medical and other evidence. In general, you are responsible for providing the evidence we will use to make a finding about your residual functional capacity. (See §404.1512(c).) However, before we make a determination that you are not disabled, we are responsible for developing your complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help you get medical reports from your own medical sources. (See §§404.1512(d) through (f).) We will consider any statements about what you can still do that have been provided by medical sources, whether or not they are based on formal medical examinations. (See §404.1513.) We will also consider descriptions and observations of your limitations from your impairment(s), including limitations that result from your symptoms, such as pain, provided by you, your family, neighbors, friends, or other persons. (See paragraph (e) of this section and §404.1529.)

(4) What we will consider in assessing residual functional capacity. When we assess your residual functional capacity, we will consider your ability to meet the physical, mental, sensory, and other requirements of work, as described in paragraphs (b), (c), and (d) of this section.

(5) How we will use our residual functional capacity assessment.

(i) We will first use our residual functional capacity assessment at step four of the sequential evaluation process to decide if you can do your past relevant work. (See §§404.1520(f) and 404.1560(b).)

(ii) If we find that you cannot do your past relevant work (or you do not have any past relevant work), we will use the same assessment of your residual functional capacity at step five of the sequential evaluation process to decide if you can make an adjustment to any other work that exists in the national

economy. (See §§404.1520(g) and 404.1566.) At this step, we will not use our assessment of your residual functional capacity alone to decide if you are disabled. We will use the guidelines in §§404.1560 through 404.1569a, and consider our residual functional capacity assessment together with the information about your vocational background to make our disability determination or decision. For our rules on residual functional capacity assessment in deciding whether your disability continues or ends, see §404.1594.

**20 C.F.R. 404.1513**

§404.1513 Medical and other evidence of your impairment(s).

(a) Sources who can provide evidence to establish an impairment. We need evidence from acceptable medical sources to establish whether you have a medically determinable impairment(s). See

**20 C.F.R. 404.1508**

§404.1508. Acceptable medical sources are—

(1) Licensed physicians (medical or osteopathic doctors);

(2) Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing mental retardation, learning disabilities, and borderline intellectual functioning only;

(3) Licensed optometrists, for the measurement of visual acuity and visual fields (we may need a report from a physician to determine other aspects of eye diseases);

(4) Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on

whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and

(5) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, "qualified" means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American Speech-Language-Hearing Association.

(b) Medical reports. Medical reports should include—

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, x-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis; and

(6) A statement about what you can still do despite your impairment(s) based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section (except in statutory blindness claims). Although we will request a medical source statement about what you can still do despite your impairment(s), the lack of the medical source statement will not make the report incomplete. See §404.1527.

(c) Statements about what you can still do. At the administrative law judge and Appeals Council levels, we will consider residual functional capacity assessments made by State agency medical

and psychological consultants and other program physicians and psychologists to be "statements about what you can still do" made by nonexamining physicians and psychologists based on their review of the evidence in the case record. Statements about what you can still do (based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section) should describe, but are not limited to, the kinds of physical and mental capabilities listed as follows (See §§404.1527 and 404.1545(c)):

(1) The acceptable medical source's opinion about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(2) In cases of mental impairment(s), the acceptable medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

(d) Other sources. In addition to evidence from the acceptable medical sources listed in paragraph (a) of this section, we may also use evidence from other sources to show the severity of your impairment(s) and how it affects your ability to work. Other sources include, but are not limited to—

(1) Medical sources not listed in paragraph (a) of this section (for example, nurse-practitioners, physicians' assistants, naturopaths, chiropractors, audiologists, and therapists);

(2) Educational personnel (for example, school teachers, counselors, early intervention team members, developmental center workers, and daycare center workers);

(3) Public and private social welfare agency personnel; and

(4) Other non-medical sources (for example, spouses, parents and other caregivers, siblings, other relatives, friends, neighbors, and clergy).

(e) Completeness. The evidence in your case record, including the medical evidence from acceptable medical sources (containing the clinical and laboratory findings) and other medical sources not listed in paragraph (a) of this section, information you give us about your medical condition(s) and how it affects you, and other evidence from other sources, must be complete and detailed enough to allow us to make a determination or decision about whether you are disabled or blind. It must allow us to determine—

(1) The nature and severity of your impairment(s) for any period in question;

(2) Whether the duration requirement described in §404.1509 is met; and

(3) Your residual functional capacity to do work-related physical and mental activities, when the evaluation steps described in §404.1520(e) or (f)(1) apply.

**20 CFR 416.926**

§ 416.926 Medical equivalence for adults and children.

(a)What is medical equivalence? Your impairment(s) is medically equivalent to a listed impairment in appendix 1 of subpart P of part 404 of this chapter if it is at least equal in severity and duration to the criteria of any listed impairment.

**20 CFR 416.927**

§ 416.927 Evaluating opinion evidence.

(a) General. (1) If you are an adult, you can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (See § 416.905.) If you are a child, you can be found disabled only if you have a medically determinable physical or mental impairment(s) that causes marked and severe functional limitations and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. (See § 416.906.) Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. (See § 416.908.)

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), includinq your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) How we consider medical opinions. In deciding whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive.

(c) Making disability determinations. After we review all of the evidence relevant to your claim, including medical opinions, we make findings about what the evidence shows.

(1) If all of the evidence we receive, including all medical opinion(s), is consistent, and there is sufficient evidence for us to decide whether you are disabled, we will make our determination or decision based on that evidence.

(2) If any of the evidence in your case record, including any medical opinion(s), is inconsistent with other evidence or is internally inconsistent, we will weigh all of the evidence and see whether we can decide whether you are disabled based on the evidence we have.

(3) If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or, if after weighing the evidence we decide we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of §§ 416.912 and 416.919 through 416.919h. We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information. We will consider any additional evidence we receive together with the evidence we already have.

(4) When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have.

(d) How we weigh medical opinions. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) Examining relationship. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) Treatment relationship. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and

may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) Length of the treatment relationship and the frequency of examination. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) Nature and extent of the treatment relationship. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When

the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) Supportability. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) Consistency. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) Specialization. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) Other factors. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) Medical source opinions on issues reserved to the Commissioner. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) Opinions that you are disabled. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) Other opinions on issues reserved to the Commissioner. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter, your residual functional capacity (see §§ 416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

(f) Opinions of nonexamining sources. We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and

psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) [Effective until Aug. 1, 2006.] At the initial and reconsideration steps in the administrative review process, except in disability hearings, State agency medical and psychological consultants are members of the teams that make the determinations of disability. A State agency medical or psychological consultant will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in Appendix 1 to subpart P of part 404 of this chapter, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(1) [Effective Aug. 1, 2006.] In claims adjudicated by the State agency, a State agency medical or psychological consultant (or a medical or psychological expert (as defined in § 405.5 of this chapter) in claims adjudicated under the procedures in part 405 of this chapter) will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in appendix 1 to subpart P of part 404 of this chapter, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law.

They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. However, State agency medical and psychological consultants and other program physicians and psychologists are highly qualified physicians and psychologists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings of State agency medical and psychological consultants or other program physicians or psychologists as opinion evidence, except for the ultimate determination about whether you are disabled. See § 416.912(b)(6).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician or psychologist, the administrative law judge will evaluate the findings using relevant factors in paragraphs (a) through (e) of this section, such as the physician's or psychologist's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations provided by the physician or psychologist, and any other factors relevant to the weighing of the opinions. Unless the treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician or psychologist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medical experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals

the requirements of any impairment listed in appendix 1 to subpart P of part 404 of this chapter. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (e) of this section.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.

(4) [Effective Aug. 1, 2006.] In claims adjudicated under the procedures in part 405 of this chapter at the Federal reviewing official, administrative law judge, and Decision Review Board levels of the administrative review process, we will follow the same rules for considering opinion evidence that administrative law judges follow under this section.